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GUIDING THE INDIAN HEALTH CARE SYSTEM THROUGH TRANSITION

Since 1995, the Indian Health Service (IHS), guided by the American Indian and Alaska Native people it serves, has been adapting to a changing environment by maintaining its strengths and responding, as necessary, to opportunities and challenges. In February 2002, the IHS charged a representative group of 20 Indian health leaders to identify changes to the Indian health care system that will best enable accessible and acceptable health care services for American Indians and Alaska Natives during the next five years.

The Restructuring Initiative Workgroup

The Restructuring Initiative Workgroup (RIW) is a group of Indian health leaders representing key stakeholders -- Tribal Leaders, representatives of Tribal and urban Indian health programs and national Indian organizations, and Federal employees. When the RIW met to discuss the Indian health care system, the group focused on the people they represent -- 1.6 million American Indians and Alaska Natives who are members of 560 federally recognized Tribes eligible to receive health care services from IHS or IHS-funded programs. The RIW discussed how to make a positive difference in the health and well-being of the people living in Indian Country. Indian Country means 661 counties on or near reservations and in rural communities in 35 States where many Indian people live. An estimated 332,000 American Indians and Alaska Natives are eligible to use the Title V Urban Indian Health programs at 36 urban sites[1].

Continuing a Partnership Process

The first stakeholder-driven design initiative for the Agency in almost 40 years spanned 18 months from 1995 to 1997 and recommended organizational and structural changes that shaped the current organization. That initiative, known as the "Indian Health Design Team" (IHDT) helped build a tradition in which tribal leaders and stakeholders are directly engaged in shaping plans and policies that affect health care programs in Indian Country.

When the IHDT recommendations were implemented, a new IHS emerged. The new IHS changed its organizational climate, shifted resources and decision making to the local level where services are delivered, and incorporated new and improved ways of doing business for IHS and IHS-funded programs. By including the people it served in the design initiative and implementing the changes they recommended, the IHS reduced the stigma of federal paternalism that has characterized other federal agencies in serving Indian people.

New Challenges are Emerging

A primary concern of RIW members is to avoid being overtaken by external forces and priorities that are different from those of Indian people. More Tribes are taking over their health care programs through Self-Determination contracts and compacts. The health care arena is rapidly evolving, particularly technology, making it costlier and more complicated to provide health care. Costs of caring for elders are growing dramatically. Moreover, alcoholism, substance abuse, and chronic health problems related to economic disadvantages and lifestyles continue to plague many Indian communities. Expectations and funding of Federal agencies evolve with each new Administration. And, fundamentally new threats, such as bio-terrorism, have emerged since the events of September 11, 2001.

When these trends are considered, it is clear that conditions affecting the Indian health care system have changed enough to again plan for the future. It is not time to sit back. The internal and external forces putting pressure on the Indian health care system will not go away if we ignore them. This is an opportunity for Indian country to guide change. If we let this opportunity pass, we run a risk that others will do it for us – maybe in ways that are not in our best interest.

This report, "Transitions 2002: A 5-Year Initiative for Restructuring Indian Health," provides a guide for transitions needed during the next 5 years. Whereas the 1995-97 design effort focused on empowering the local level and downsizing at the top, this effort focuses on realigning the system to carry out its work in a different internal and external environment.

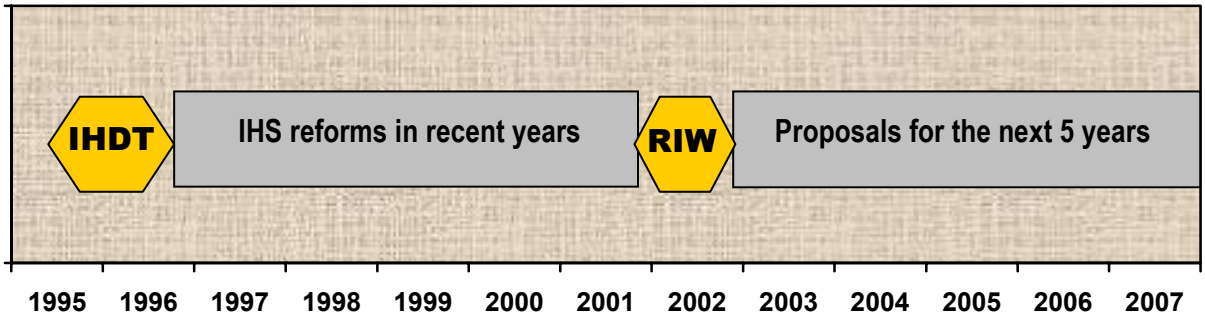

Figure 1.1, IHS Transitions through the Years

Dialogue with Indian Country

The process includes Tribal consultation before IHS takes any actions that affect American Indian and Alaska Native people. By this report, the Workgroup encourages dialogue within Indian Country to address the question: In a changing environment, how will the operators of Indian health care programs continue to provide quality health care to American Indians and Alaska Natives? The answer to this question will emerge after consultation is completed and the Indian people have provided their response to the IHS.